

Diagnosis of Abdominal Tumours.

Lo Spallanzani has recently published a lecture under the name of Prof. BACCCELLI on the diagnosis of tumours of the abdomen. We give the following *résumé* of the principal diagnostic points:—

Before all, it must be determined whether the tumour is situated within or external to the peritoneal cavity. Extraperitoneal tumours are distinguished by a clear and tympanitic resonance due to the presence of the intestinal mass behind them; it should, however, be remembered that this sign may fail when the intestines are filled with feces, when there is a concomitant ascites, when the tumour attains such a size that it presses on all parts of the abdominal walls, or when the tumour is in contact with some voluminous intraperitoneal organ, such as the liver.

On the other hand, the tympanitic note may be present in the case of tumours of the liver or spleen, if they are covered by intestinal loops.

Observation of the movements of the tumour during inspiration and expiration may give very precise information.

Thus, the intraperitoneal tumour is depressed in inspiration and elevated in expiration. Retroperitoneal tumours, if exploration by the touch is possible, seem to slip under the hand.

Tumours of the abdominal walls, on the other hand, are elevated and depressed in a line perpendicular to the axis of the body, because in inspiration the distance between the anterior and posterior walls of the abdomen is increased. An intraperitoneal tumour, however, may remain immovable if it has formed adhesions to the anterior abdominal wall or with the pelvis, or if the diaphragm or lungs are inactive.

A retroperitoneal tumour can also be movable if displaced, as a floating kidney; or if it is adherent to an intraperitoneal organ.

Backward movements of the tumour will be prevented by adhesions to the anterior abdominal wall. If the tumour is small and slightly movable, or independent of the respiratory movements, its change of position can be readily recognized from the exterior.

It is indispensable to study the tumour in connection with the region in which it is found; thus, it is known that the kidney may be displaced in front of the liver and so simulate a hepatic tumour. So also a pleural exudation may be mistaken for hypertrophy of the liver.

Tumours of the epigastrium may depend upon the stomach, peritoneal exudation consecutive to some ulcerative process, or upon echinococcus or cancer of the left lobe of the liver.

Tumours of the umbilical region, when not implicating the organs normally in this region, may depend upon a depressed pylorus, on a displaced spleen or kidney, or on a urinary calculus closed in the urachus.

Tumours of the hypogastric region may be caused by the distended bladder, the gravid uterus, ovarian or uterine tumours, or encysted exudations.

Tumours of the iliac and inguinal fossæ can be produced by fecal matter in the cæcum, by neoplasms of the intestine, by abscess, local peritonitis, or affections of the vermiform appendix.

It is also necessary to examine the form of the abdomen to see whether the normal outline has been departed from.

Splenic tumours, in elevating the costal arcs, raise the abdominal walls and give the abdomen a pyriform appearance, with the point directed towards the pubis.

Tumours of the kidney, on the other hand, pressing on the ribs, give the abdomen a very irregular outline.

In the case of tumours of the hypochondrium the umbilicus approaches the pubis and is elongated.

In tumours which are developed deep in the abdomen the umbilicus may be slightly depressed and stretched laterally, and the median raphe slightly deviated to the side on which the tumour is present.

The dilatation of the peri umbilical veins, the so-called *head of Medusa*, is a sign of obstructed circulation of the portal vein, and is very well marked in central tumours of the liver.

The other dilatations of the epigastric veins indicate interference with the circulation in the inferior vena cava, although obstructed portal circulation may also cause them. It is also necessary to consider displacements of other organs.

In tumours of the spleen the cardiac ventricles maintain their normal position; in tumours of the kidney the stomach is completely displaced; and in large tumours the stomach may form an arc of a circle, its concavity corresponding to the convexity of the internal border of the tumour.

In tumours of the kidney the colon preserves its anatomical position; but when the tumours are very large it may be pushed behind or flattened.

The lower limit of the thoracic cavity must be always accurately limited by percussion, as in tumours of the hypochondrium, which cause tension on the diaphragm, the complementary pleural angle nearly always disappears. This is also usually the case in tumours of the kidney.

It is also to be noticed that in movable kidneys, in the standing position or even in the dorsal decubitus, a hollow can be observed in the corresponding lumbar region, and the kidney cannot be felt by palpation.—*L' Abeille Méd.*, July 3, 1882.

SURGERY.

Thyrotomy for Removal of Foreign Bodies Impacted in the Interior of the Thyroid Cartilage.

At a late meeting of the Royal Medical and Chirurgical Society Mr. T. HOLMES read a paper on this subject. The history of a case was related in which a large and rough piece of rabbit-bone was impacted in the neighbourhood of the left vocal cord for seven days before its removal. On the failure of attempts to extract it with the laryngeal forceps from the mouth, laryngo-tracheotomy was performed on the fifth day; and as the bone was still immovable, the thyroid cartilage was divided on the seventh day, when the piece of bone was at once extracted. The patient had suffered rather severely from inflammation of the mucous membrane of the larynx and trachea before the operation, and this did not subside after the operation, but spread gradually down to the lungs, until finally a gangrenous abscess formed in one lung, and the patient died nine weeks after the operation. Post-mortem examination showed evidences of intemperate habits, which were, indeed, also known from the patient's history. The voice had almost entirely returned before the patient's death, and the wound had contracted to a very minute fistula. The parts concerned in the operation were exhibited, and showed hardly any unnatural appearances. There was slight ulceration of the left vocal cord, caused by the foreign body, and a very minute perforation still existing in the thyroid cartilage above the glottis; but the wound, which extended from the upper border of the pomum Adami to the second or